PREVIOUS EDITION IS NOT USABLE

NSN 7540-00-634-4276

MEDICAL RECORD | **PRENATAL AND PREGNANCY** | DATE

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL

STREET ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE *(Home)*		TELEPHONE *(Work)*			ID NUMBER	DAY OF BIRTH *(Month, Day, Year)*	AGE
AREA CODE	NUMBER	AREA CODE	NUMBER	EXT.			

RACE

- ☐ WHITE
- ☐ BLACK
- ☐ HISPANIC WHITE
- ☐ HISPANIC BLACK
- ☐ AMERICAN INDIAN/ALASKA NATIVE
- ☐ ASIAN/PACIFIC ISLANDER

EDUCATION *(Last grade completed)*

OCCUPATION

- ☐ HOMEMAKER
- ☐ STUDENT
- ☐ OUTSIDE WORK

MARITAL STATUS

- ☐ SINGLE
- ☐ DIVORCED
- ☐ SEPARATED
- ☐ WIDOWED

TYPE OF WORK

EMERGENCY CONTACT	TELEPHONE	
	AREA CODE	NUMBER

HUSBAND/FATHER OF BABY

NAME	TELEPHONE		NEWBORN'S PHYSICIAN	REFERRED BY
	AREA CODE	NUMBER		

FINAL ESTIMATED DELIVERY DATE	HOSPITAL OF DELIVERY	PRIMARY PROVIDER/GROUP	MEDICAID NUMBER/INSURANCE

NUMBER OF PREGNANCIES

TOTAL	FULL TERM	PREMATURE	ABORTIONS INDUCTED	ABORTIONS SPONTANEOUS	ECTOPICS	MULTIPLE BIRTHS	LIVING

PAST PREGNANCIES *(LAST SIX)*

DATE *(MO/YR)*	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX	TYPE DELIVERY	ANESTHESIA	PLACE OF DELIVERY	PRETERM LABOR DELIVERY	COMMENTS/ COMPLICATIONS
FMYESN									

MENSTRUAL HISTORY

LAST MENSTRUAL PERIOD		MENSES		FREQUENCY			MENARCHE	
☐ DEFINITE	☐ APPROXIMATE (MONTH KNOWN)	MONTHLY	PRIOR *(Date)*	Q *(Days)*	ON BCP AT CONCEPT		AGE ONSET	hCG + *(Date)*
☐ UNKNOWN	☐ NORMAL AMOUNT/DURATION	(Y)						
☐ FINAL:		(N)			YES	☐		

SYMPTOMS SINCE LAST MENSTRUAL PERIOD

DESCRIBE ALL SYMPTOMS

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER *(SSN or Other)*
NO	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID No. or SSN; Sex)*

REGISTER NO.	WARD NO.

PRENATAL AND PREGNANCY
Medical Record

STANDARD FORM 533 (REV. 12-1999)
Prescribed by GSA/ICMR FMR (41 CFR) 101-11.203

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

PAST MEDICAL HISTORY

ITEM	O NEG + POS	DETAIL POSITIVE REMARKS *(Include Date and Treatment)*	ITEM	O NEG + POS	DETAIL POSITIVE REMARKS *(Include Date and Treatment)*
DIABETES			PULMONARY (TB, ASTHMA)		
HYPERTENSION			ALLERGIES (DRUGS)		
HEART DISEASE			BREAST		
AUTOIMMUNE DISORDER			HISTORY OF ABNORMAL PAP		
KIDNEY DISEASE/UTI			UTERINE ANOMALY/ DES		
PSYCHIATRIC			INFERTILITY		
NEUROLOGIC/ EPILEPSY			RELEVANT FAMILY HISTORY		
HEPATITIS/LIVER DISEASE			GYN SURGERY		
VARICOSITIES/ PHLEBITIS					
THYROID DYSFUNCTION			OPERATIONS/HOS-PITALIZATIONS *(Year and Reason)*		
TRAUMA/DOMESTIC VIOLENCE					
HISTORY OF BLOOD TRANSFUSION			ANESTHETIC COMPLICATIONS		
D (RH) SENSITIZED			OTHER *(Specify)*		

USE OF TOBACCO			USE OF ALCOHOL			USE OF STREET DRUGS		
NUMBER OF CIGARETTES PER DAY		NO. OF YEARS SMOKED	NUMBER OF DRINKS PER DAY		NO. OF YEARS DRINKING	AMOUNT PER DAY		NO. OF YEARS USE
PRIOR TO PREGNANCY	NOW		PRIOR TO PREGNANCY	NOW		PRIOR TO PREGNANCY	NOW	

COMMENTS/COUNSELING

GENETICS SCREENING/TERATOLOGY COUNSELING

(Includes Patient, Baby's Father, or anyone in Either Family)

ITEM	Y	N	ITEM	Y	N
PATIENT'S AGE IS GREATER THAN 35 YEARS			MENTAL RETARDATION/AUTISM		
THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND *(MCV IS LESS THAN 80)*			IF YES, WAS PERSON TESTED FOR FRAGILE X		
NEURAL TUBE DEFECT *(MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)*			OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
CONGENITAL HEART DEFECT			MATERIAL METABOLIC DISORDER *E.G., INSULIN-DEPENDENT DIABETES, PKU)		
DOWN SYNDROME					
TAY-SACHS (E.G., JEWISH, CAJUN, FRENCH CANADIAN)			PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
SICKLE CELL DISEASE OR TRAIT (AFRICAN)					
HEMOPHILIA			MEDICATIONS/STREET DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
MUSCULAR DYSTROPHY					
CYSTIC FIBROSIS			IF YES, LIST AGENT(S)		
HUNTINGTON CHOREA					
RECURRENT PREGNANCY LOSS OR A STILLBIRTH			ANY OTHER		

COMMENTS/COUNSELING

Genetic Testing for Cystic Fibrosis Information Sheet & Pre-test

Date_____ Name_____ Age_____

Sponsor's SSAN_____ Phone number _____

Are you pregnant? ☐Yes ☐No If yes, is this your first baby? ☐Yes ☐No

Last Menstrual Period: _____

What are your parents' ethnic (racial) backgrounds?

☐ White non-Hispanic ☐ African American ☐ Ashkenazi Jewish
☐ Hispanic ☐ Asian ☐ other _____

Using the above list, what is your partner's ethnic background?_____

Is there anyone in your or your partner's family with cystic fibrosis:
☐Yes ☐No If yes, who? _____

Have you ever been tested for cystic fibrosis before?
☐Yes ☐No If yes, when and where?_____

Cystic fibrosis is a severe illness which begins in early childhood and causes problems with the digestion and breathing. Testing is available to identify couples who may be at high risk for having a baby with cystic fibrosis. Please take this short quiz to see how much you know about this potential problem for your baby.

1. ☐True or ☐False: Cystic fibrosis is an inherited disease.

2. If a person has cystic fibrosis, he or she has inherited two abnormal genes for this condition,
   ☐ a. 1 from the mother and 1 from the father
   ☐ b. Both from the mother
   ☐ c. Both from the father
   ☐ d. From neither parent

3. ☐True or ☐False: You can carry one abnormal gene for cystic fibrosis and not have any health problems from it.

4. In which ethnic group is cystic fibrosis most common?
   ☐ a. African Americans
   ☐ b. Asian Americans
   ☐ c. Hispanic Americans
   ☐ d. European Caucasians

5. ☐True or ☐False: Genetic testing for cystic fibrosis is usually a blood test.

6. ☐True or ☐False: Genetic testing for cystic fibrosis can tell 100% that a person does not carry an abnormal gene for the condition.

7. ☐True or ☐False: A baby can have cystic fibrosis if only one of its parents is a carrier.

8. ☐True or ☐False: If both parents are found to be carriers for cystic fibrosis, they must have a test done on their baby before it's born.

9. ☐True or ☐False: A person's ethnic (racial) background can change how likely a genetic test for cystic fibrosis will com back abnormal.

#######

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER *(SSN)*

Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United States Code and Executive Order 9397.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.

3. ROUTINE USES

The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/ beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but CARE WILL NOT BE DENIED.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

SIGNATURE OF PATIENT OR SPONSOR	SSN OF MEMBER OR SPONSOR	DATE